

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>EASTLAKE TERRACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3109 E BRISTOL ELKHART, IN 46514</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00192236.</p> <p>Complaint IN00192236- Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey date: February 5, 2016.</p> <p>Facility number: 010065 Provider number: 010065 AIM number: N/A</p> <p>Residential census: 87</p> <p>Sample: 3</p> <p>Eastlake Terrace was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00192236.</p> <p>QR was completed by 99993 on 02/08/16.</p>	R 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE